Dear Valued Patient,

Thank you for your interest in the St. Elizabeth Healthcare Financial Assistance Program.

Please complete the attached application, listing all members of the family and income for all adult members. "Family" shall include any dependent claimed for federal tax purposes. The following documentation must be included in order to process your application: Copies (**do not send originals**) of proof of income, which includes your prior year tax return and your most recent pay stub. If you have an income source other than employment, such as social security, pension, unemployment, etc., please send a copy of the benefit letter stating your monthly or weekly benefit amount. If you have no income, please complete the Unemployed section of the application, explaining how you are obtaining food, housing, transportation, etc.

If verification of income is not included your application will be returned with a request for the documentation!

You may submit your application by any of the following means:

- Via Mail: St. Elizabeth Healthcare
  Attn: Self-Pay / Financial Assistance
  1 Medical Village Dr.
  Edgewood, KY 41017
- Via Email: financialassistance@stelizabeth.com
- Via Fax: 859-655-3537
- In Person: Drop off for financial counselor in the registration area of St. Elizabeth Healthcare's Edgewood location

Applications will be processed upon receipt of all requested documentation. All applicants completing the application process will receive notification by mail, stating approval or denial for the program.

This application may also be applied to bills you may be receiving from St. Elizabeth Physicians.

PLEASE ALLOW AT LEAST 30 DAYS FOR PROCESSING!

For application questions, please call 859-655-1925 Monday through Friday between the hours of 8:00 a.m. and 3:00 p.m.

Thank you,

St. Elizabeth Healthcare

Patient Application for Financial Assistance for St. Elizabeth Hospital and Physician Visits

This single financial assistance application form may be used for both hospital and physician services. However, hospital and physician services utilize different income parameters to qualify patients, award different discount percentages, and will communicate approval or denial independently.

Full Name:_______________________________________ Phone:__________________________________

Address:____ Employer:________________________________

____

Family Member Name's	Account Number (list just one if applicable)	DOB	SSN
Patient:			
Spouse:			
Dependent:			
Dependent:			
Dependent:			
Dependent:			
Dependent:			
Dependent:			

Financial assistance qualification is determined upon the applicant's household income, as a percentage above the federal poverty guidelines.

Please answer the following questions below, if answering yes please provide the required documents with your application. Please provide copies of the requested documentation ***for all adult family members***. "Family" shall include any dependent claimed for federal tax purposes. If specific documentation is not included, we will be unable to process your application**.**

Yes/No	Question	If Yes, Required Documents
	Do you file taxes	Most recent federal tax return
	Is anyone in the home employed	most recent pay stub per person
	Do you receive Social Security	Annual Award Letter
	Do you receive Disability	Annual Award Letter
	Do you receive unemployment	Benefit Letter
	Do you receive retirement/pension income	Monthly Benefit Letter or Bank statement
	Are you Self-Employed	2 Month income/expense report
	Do you have any income not mentioned	Documentation to support
	Are you claiming $0 income	Zero Income Verification (attached)

Do you have any real estate or financial assets such as savings acct? **Yes / No**

If Yes, please explain: ____

____

____

Please provide the following information based on average income over the last 12 months.

Monthly Family Income & Source		
	Patient	**Spouse**
Monthly Salary (Gross)	$	$
Unemployment Benefits	$	$
Social Security	$	$
Workman's Compensation	$	$
Alimony	$	$
Short/Long Term Disability	$	$
Retirement/Pension	$	$
Self-Employment	$	$
Other	$	$
Total Family Income	**$**	

Monthly Expenses

Housing……………. $___________ Utilities………….. $__________ Household Expenses……….. $___________

Automobile………... $___________ Other……………. $__________ (food, etc.)

Other information you would like to provide: ____

____

____

Upload completed application and income documents through your St. Elizabeth MyChart account.

Please note that documentation is required for all adult family members. Failure to provide necessary documentation may result in a delay in getting the application processed or a denial.

I attest that the above information is current and accurate:

Patient Signature:____ **Date:**_________________________

Spouse Signature:____ **Date:**_________________________

For additional information on St. Elizabeth hospital or physician financial assistance programs, please visit:
https://www.stelizabeth.com/resources/pay-my-bill
https://www.stelizabethphysicians.com/resources/pay-my-bill/

Zero Income Verification

I, ____, confirm:

1. My place of residence is:

   ____.

2. I am (please circle one): **single** **married** **separated** **divorced.**
3. I claim the following dependents (names & DOB):

   ____

   ____

4. I have been unemployed since (month/year): ____.
5. I currently have no income of any kind including salary and wages, interest income, dividend income, social security, workers compensation, disability payments, unemployment income, business income, rentals and royalties, inheritance, strike benefits, alimony income, and/or payments received from the state for legal guardianship or custody.
6. I am currently obtaining food and housing through the following sources:

   ____

   ____

Patient Signature:____

Date:______________________________